



Board of Massage
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Intraoral Massage Endorsement Application Packet

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Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with Initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Board of Massage
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly. It is your responsibility to submit the correct forms required.

☐ **Application Fee.** This fee is non-refundable. You can check the [fee page](#) for current fees.

☐ **Step #1: Demographic Information:**

Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name.

Definition of legal name: Legal name is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the city, state, and country where you were born.

Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, county and country. This will be your permanent address with Department of Health until we have been notified of a change.
See [WAC 246-12-310](#).

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers, if you have them.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See [WAC 246-12-300](#).

☐ **Step #2: Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and it will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **#3: Previous Credentialing:**

List all states and/or jurisdictions, U.S. and foreign, where you have a health care practitioner credential. Please list all active, inactive and expired credentials. Please list credential type. If you need more space, attach a piece of paper.

☐ **#4: Applicant's Attestation:**

You must sign and date this in order to process the application. Read this very carefully.

Massage Training Information:

Provide a chronological listing of your educational training. If you need more space, attach a piece of paper.

Training: Provide a listing and submit documentation of all intraoral massage training you have successfully completed.

A massage practitioner licensed under [RCW 18.108](#) may apply for an endorsement to perform intraoral massage upon completion of intraoral training.

16 hours of direct supervised training must include the following:

- Hands-on intraoral massage techniques, cranial anatomy, physiology, and kinesiology.
- Hygienic practices, safety and sanitation.
- Pathology and contraindications.

Supervised training must be obtained from a licensed massage practitioner endorsed in intraoral massage or from an individual who is licensed, certified, or registered and who has performed intraoral massage services within their authorized scope of practice.

Provide a completed verification of intraoral massage training form. This form needs to be signed by the individual who provided the required intraoral massage training

Background
Check
Stamp
Here

Date
Stamp
Here

Revenue 024201000

Intraoral Massage Practitioner Endorsement

Please type or print clearly. It is the responsibility of the applicant to submit or request all required supporting documents be submitted. Failure to do so could result in a delay in processing your application. Make sure you have read and understand the instructions.

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions.)

☐ Male

☐ Female

— —

Name

First

Middle

Last

Birth date (mm/dd/yyyy)

Place of birth

City

State

Country

Address

City

State

Zip

County

Country

Phone ()

Fax ()

Cell ()

Email address

Mailing address (if different from above)

City

State

Zip

County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

Issuance Date _____ Certification # _____

Validation Date _____ Received _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation..... ☐ ☐

“Medical Condition” includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

- 1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.
- 1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

Note: If you answered “yes” to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

“Currently” means within the past two years.

“Chemical substances” include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism?..... ☐ ☐
4. Are you currently engaged in the illegal use of controlled substances?..... ☐ ☐

“Currently” means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer “yes” to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ... ☐ ☐

Note: If you answered “yes” to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (cont.)

Yes No

- a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction ☐ ☐

Note: If you answered “yes” to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

- b. If you answered “yes” to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete? ☐ ☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have:
- a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
- b. Diverted controlled substances or legend drugs? ☐ ☐
- c. Violated any drug law? ☐ ☐
- d. Prescribed controlled substances for yourself? ☐ ☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If “yes”, please attach an explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

3. Other License, Certification, or Registration

List all states including Washington where licenses/certifications/registrations are or were held.

State	License/certification/registration type	License/certification/registration		Method of license		
		Year Issued	Number	Exam	End	GF

4. Applicant's Attestation

I, _____, declare under penalty of perjury under the laws of
(Print applicant name clearly)
the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read [RCW 18.130.170](#) and [RCW 18.130.180](#) of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ in _____ (city, state)
mm/dd/yyyy

By: _____
Signature of applicant

Verification of Intraoral Massage Training

This form may be duplicated. Fill out Section 1 and forward the verification form to the trainer for completion.

1. Print or Type Clearly:

Name _____ Birthdate _____
Address _____
City _____ State _____ Zip _____

2. Approved Trainer

The above individual seeks verification of direct supervised intraoral training to place an intraoral massage endorsement on his/her massage therapy license. Please complete the following:

Trainer Name _____ Current Phone _____
Address _____
City _____ State _____ Zip _____
Trainer credential and credential number _____ Dates Credentialed _____

3. Training Specific to Intraoral Massage:

Sixteen hours of direct supervised training must include: Hands-on intraoral massage techniques, cranial anatomy, physiology, and kinesiology; hygienic practices, safety and sanitation; and pathology and contraindications.

Direct Supervised Intraoral Training Hours _____

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the department may request more information, if it is needed, to evaluate the application of the individual named on this document. I declare under penalty of perjury under the laws of the state of Washington that the following is true and correct:

- ☐ I am a licensed massage practitioner endorsed in intraoral massage.
- ☐ I am an individual licensed, certified, or registered and have performed intraoral massage services within my authorized scope of practice.

Signature _____ Date _____
Qualified Trainer

Return this form to:
Department of Health
Board of Massage
PO Box 47877
Olympia WA 98504-7877

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Health Professions Reference Numbers and Links

RCW/WAC Links

Uniform Disciplinary Act..... [UDA RCW 18.130](#)

Administrative Procedure Act [APA RCW 34.05](#)

Administrative procedures and requirements [WAC 246-12](#)

AIDS Courses

Health Impact 1.800.783.2437 **or** 206.284.3865

W.F. Professional..... 1.800.323.4305

AIDS Resources 206.784.5655

On-Line

Board of Massage [Web page](#)

National Certification Board..... [www.ncbtmb.com](#)

AIDS Training [Reference Page](#)

Federation of State Massage Therapy Boards..... [www.fsmtb.org](#)

Board of Massage [School Approval](#)

Currently Approved Jurisdictions..... [Web Page](#)

Jurisprudence Exam [Online link](#)

Required Hours of CE Training (after license has been issued).... 16 hours every 2 years